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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

#2 acceptable

PRINTED: 03/04/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		3	700000000000000000000000000000000000000	TED D
			445303	D, 9011	—— —		03/0	3/2011
	PROVIDER OR SUPPLIER HEALTH AND REHAL	BILITATION C	CENTER		33	EET ADDRESS, CITY, STATE, ZIP CODE 882 ANDERSONVILLE HIGHWAY NDERSONVILLE, TN 37705		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CEDED BY FULL	PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279 SS≔D	C/O #26200, #2620 #26879, 27171, #2 #27297 and #2753 7-22, 2011, at Norr Center. No deficiel #26200, #26203, # 483.20(d), 483.20(l) COMPREHENSIVE A facility must use to develop, review a comprehensive pla The facility must deplan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any side to the resident's §483.10, including funder §483.10(b)(4) This REQUIREMENT.	o3, #26232, #7223, #2725. 1 were investing in the results of and revise the results of and mental and the results of and mental and the results of and mental and the results of an and mental and the results of an another results of the right to results. Also a sexercise of the right to results and mental and the right to results.	3, #27271, tigated February d Rehabilitation ited for C/O 79. OP NS f the assessment he resident's prehensive care des measurable et a resident's hd psychosocial comprehensive e services that are tain the resident's ental, and ired under would otherwise are not provided f rights under efuse treatment	73	2279	HOW WILL CORRECTIVE BE ACCOMPLISHED FOR RESIDENTS FOUND TO HESEN AFFECTED BY THE DEFICIENCT PRACTICE? Resident #6 Care Plan updated DON to reflect the skin condit 3/1/11 Resident #14 Care plan was up the unit manager to reflect the 2/24/11 HOW WILL THE FACILIT IDENTIFY OTHER RESID HAVING THE POTENTIAL AFFECTED BY THE SAME DEFICIENT PRACTICE? All current residents received a toc skin assessment on 2/28/by licensed nurses working this dependent of the potential of the potenti	THOSE AVE I by the ion on odated by falls on Y ENT S L TO BE A head to the ay and the ew non-ntified. The ified skin view to	3/28/11
	Based on medical r review, observation failed to update the (#6) with a wound a (#14) of twenty-two	and intervie care plan for and one resid	w, the facility r one resident lent with falls	*		All residents who experienced 3/1/11 were reviewed by the D determine if a care plan for according prevention efforts was in place	ON to idents and	5 2 2 8
ABORATORY	DIRECTOR'S OR PROVIDE	LSO (2	REPRESENTATIVE'S SIG	NATURE		Adm.	3/	(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CY0311

Facility ID: TN0103

If continuation sheet Page 1 of 28

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FORM APPROVED OMB NO. 0938-0391

DEPARTME	ENT OF HEALTH	AND	HUMAN SERVICES			FORM APPROV OMB NO. 0938-03	
CENTERS I STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) P	DICAID SERVICES ROVIDER/SUPPLIER/GLIA ENTIFICATION NUMBER:			ULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED	
			445303	B. WI	NG_	C 03/03/2011	
	VIDER OR SUPPLIER	ILITA	TION CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705	
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Ref 14 De Se Di Per en me de ste ul Minor ex Per en me de ste ul me de ste ul me per en	4, 2006, with diagrementia, Alzheime eizure Disorder ar isorder. Medical rata Set (MDS) data Set	ed: Imitte noses er's D nd Pe ecord ed O nt had and se elled, " ed attent ed on oruan nt wa uze b tervie the R ecord eters ter" w serum ew ar	sease, Hypertension, ipheral Vascular review of the Minimum ctober 28, 2010, short and long-term verely impaired as totally dependent on kin problems. the care plan revealed sident had any lower	F	279	WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR? Licensed Nurses were in-serviced on 3/11/11 addressing by the SDC regarding: A) weekly skin check and Care plan need for identified wounds. B) Addressing the need to update the care plan for falls and incorporating new interventions for each fall. (3 PRN nurses are left for in- servicing- they will not be allowed to work until in-service is completed) Clinical leadership (DON, Unit Managers) were in-serviced on 3/18/11by the Admin, and SDC regarding updating care plans to include safety devices and Post fall interventions as well as Care Plans for skin impairments. A weekly wound report is developed utilizing the weekly skin checks and weekly wound measurements and assessment forms. This report will be used by the DON, Unit managers to audit the medical records of 3 random charts weekly for 4 weeks then monthly time 3 months to determine if the Care Plans are in place. The facility will conduct a weekly Action Team Meeting to review Incidents and Accidents and during this process is completed to determine if the care plans are in place.	

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	OF DEFICIENCIES F CORRECTION	(X1) [ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION IG	(X3) DATE SU COMPLE	TED RVEY
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NAME OF P	ROVIDER OR SUPPLIER				STR	REET ADDRESS, CITY, STATE, ZIP CODE		
NORRIS	HEALTH AND REHA	BILITA	TION CENTER			ANDERSONVILLE, TN 37705		
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F 279	care plan had not to wound on the right related to the wour Resident #14 was 27, 2010, with diag Gastrointestinal Rehip with Left Hemireview of the MDS revealed the reside decision-making stansistance with be ambulation; was unseated to a standlir on and off the toile bed and chair; was bladder; and had at to six months prior Medical record reveasessments date 7, and December was at high risk for Review of a "Chan December 12, 201 alarm. Found residedno injuries no "Interdisciplinary Foundwill apply the sound resident standard resident resident standard resident	Work leen lowe lowe lowe lowe lowe lowe lowe lowe	er's office confirmed the pdated to reflect the leg or interventions ted to the facility on May including Dementia, lisease and Fractured oplasty. Medical record December 7, 2010, d no impairment of equired extensive lifty, transfers and may when moving from a sition, ambulating, moving transferring between the tinent of bowel and my of falls in the prior one mission. The "Fall Risk" 27, June 3, September 0, revealed the resident condition" dated ealed, "Heard cliph floor sitting up beside" Review of the facility's	F	279	Charles and the second	determine determ	
	December 7, 2010	, revo	the care plan dated aled the care plan had ude a clip alarm as an					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/04/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/ IDENTIFICA	SUPPLIER/CLIA TION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SUF COMPLET	ED
		4	145303	B. WING _		03/03	; /2011
	ROVIDER OR SUPPLIER HEALTH AND REHAI	BILITATION CE	ENTER	3	EET ADDRESS, CITY, STATE, ZIP CODE 382 ANDERSONVILLE HIGHWAY INDERSONVILLE, TN 37705		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) GOMPLETION DATE
F 279 F 281 SS=D		ty's policy for in DT (Interdiscip mplements a continuity on Fermi is not current terview on Fermi is not current terview on Fermi is not current terview on Fermi is not method to the clip alident. In the clip alident is aligned the clip alian is not method to the risk of RVICES PROYSTANDARDS ded or arrange ional standard in the clip alian is not method in the clip alian is not	care Plan and repeat falls. The ed as indicated at, arrange to bruary 15, 2011, med the clip sident. bruary 16, 2011, evelopment arm was not iew with LPN 5, 2011, at 9:30 d not been as an falls. VIDED MEET ed by the facility is of quality.	F 279	HOW WILL CORRECTIVE BE ACCOMPLISHED FOR RESIDENTS FOUND TO HA BEEN AFFECTED BY THE DEFICIENCT PRACTICE? Resident # 9 was discharged fr facility due to behavior issues a escorted via the Police departm further interventions can be ma time for this resident.	THOSE AVE om the and was eent. No	3/28/11

THEN THE THE GREEN

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	19 LOW MEDICALE	OF INITE	JICHID SEITVICES	-		THE RESERVE OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN	7	
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION		OVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	LED
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7,571(1877)2711(28,21)	ROVIDER OR SUPPLIER	BILITAT	TION CENTER		33	REET ADDRESS, CITY, STATE, ZIP CODE 382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST B	OF DEFICIENCIES SE PRECEDED BY FULL TIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION SHOULD BE COMPLE THE APPROPRIATE DAT	
F 281	The findings included Resident #9 was accorded 14, 2010, Brain Injury related Medical record revidated October 21, had impaired cogniproblems; required transfers, ambulational used a walker. Medical record revidocumentation date the following: Nove to) resident behaviogoals discussed infor possible admissible health) order to evamanagement of birdisorderbehavior 7-"Room (change)over roommate yell 16-"(Rehabilltation their unit"; Noven sonresident (not) environment"; No (information) to (accompless)(no) be 17-"Info faxed to (b. 19-"(Increased) be (change)Ordert #2) for eval" and returned 11-19-10 eval. Will continue more suitable. Sta	dimitted with dia to a more worth to a more tive skill limited on in the for mobile work of the work o	agnosis of Traumatic otor vehicle accident. he Minimum Data Set evealed the resident ills and memory assistance with he room and hallways; bility. Social Worker ember 2010, revealed 3-"Room (changed due h) roommate, plans and ehabilitation Hospital) November 8-"(Mental uate)psychosis dissues"; November ratic behavior "standing November al) denied transfer to 2-"Spoke (with) poriate for this er 17-"Faxed info the hospital #1) for allable"; November unit)"; November unit)"; November mood at to (acute care hospital alber 19- "Resident thy from hosp (hospital) et (and) find placement	F	281	HOW WILL THE FACILIT IDENTIFY OTHER RESIDINATING THE POTENTIAL AFFECTED BY THE SAME DEFICIENT PRACTICE? A record review by the DON of transfers since 3/1/11 to acute facilities was reviewed to deter transfer information, medical it was sent with the resident. All transfers had appropriate it sent with the resident. WHAT MEASURES WILL INTO PLACE OR SYSTEM CHANGES MADE TO ENSITHAT THE DEFICIENT PRACTICENT PRACTICE	of the care rmine if information informati	

PRINTED: 03/04/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) FROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 03/03/2011 445303 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3382 ANDERSONVILLE HIGHWAY NORRIS HEALTH AND REHABILITATION CENTER ANDERSONVILLE, TN 37705 PROVIDER'S PLAN OF CORRECTION COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG TAG DEFICIENCY) F 281 F 281 Continued From page 5 HOW WILL THE FACILITY MONITOR ITS CORRECTIVE Medical record review of a physician's order ACTIONS TO ENSURE THAT THE dated November 30, 2010, revealed, "Send...to DEFICIENT PRACTICE WILL NOT (hospital)...to evaluate fdr medical clearance for (mental health institute) because pt. (patient) is a RECUR? threat to others-pt. can not remain in (facility) because we can not meet...needs." Medical Results of the random transfer audit will record review revealed the resident was be presented to the monthly QAA transferred to the hospital and returned to the committee for review. If identified issues facility on November 30, 2010. are determined then adjustments to the plan of correction will be made. Medical record review of documentation by the Social Worker dated December 2010, revealed QAA committee will monitor this for 4 the following: December 14, at 1:35 p.m.-"Called months or longer depending if this plan is son...again re(regarding) DC (discharge) to his successful. care. Son very aggravated at health system...informed son resident DC'd (discharged) at 12 pm...Son needs to pick pt up now...has been discharged with lengthy notice. Son very verbally abusive, using profanity. SS (Social Services) informed son bt (patient) is now being aggressive, wandering and potential for combativeness in facility...must come et pick...up..."; December 14, -"SS called 911...to remove resident to hospital D/T agitation, combative actions et hollering in hallways..."; December 14, at 5:30 plm.-"...removed from facility via hand-cuffs (with) assist of two officers. Report called to (hospital #2)...very combative, belligerent...unstable actions...Informed (hospital staff) pt. can not return to facility..."; December 15-"Resident was returned to (facility) on December 12/14/10..."; December 15, at 2:15

p.m.-"Info faxed to (another long-term-care facility)..."; and December 15, at 6:25 p.m.-"Info faxed to (another facility)..." Continued review of Social Worker notes revealed the following: December 16, at 3:00 p.m.-"...wandering throughout facility becoming increasing agitated. Staff 1:1 (one-on-one) continuously due to

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
			445303	B. Wit	10 <u> </u>			3/2011
	ROVIDER OR SUPPLIER HEALTH AND REHA	BILIT	ATION CENTER		33	EET ADDRESS, CITY, STATE, ZIP CODE BB2 ANDERSONVILLE HIGHWAY NDERSONVILLE, TN 37705		
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F 281	sporadically at oth 3:15 p.m., "Called of pt. Unable to mothers. Moods et Officers arrived at removal. Called (removal from facil behaviorsspoke ofaggressivenes family support, ab depth patient is not o uncontrollable in harmful to others."Spoke (with) osituation et could risk et possible hanurse statedfelt there was no reas (hospital #3)"; a (manager)(hospital #3) is no informed her (faci to safety riskwill on 12/17" Medical record re resident was rece (Emergency Roor 16, 2010, and was son on December Medical record redated December sent to ER." Telephone Intervial with the Control of the control o	belligers ca 911 fileet no behave facility due with case, a has a harge to be no do so a high and a case, a high a high a case, a high a high a case, a high a case, a high a high a case, a high a high a case, a high a	erent, hollering out busing more disruption"; or assistance et removal eds et safety of self et ors uncontrollable. (5 officers) for all #3) to inform of to aggressive harge nursegave report arm to self et others, poor behavior. Explained in returned to (facility) due behaviors, unsafe et h risk"; 10:51 p.m. hurseexplained cept pt back due to safety self et otherscharge dumped on them et him to be admitted to 1:35 p.m., "Case Mgr contacted SSStating hat Institution. SS n not acceptback due to directly to her in a.m. Hospital #3) revealed the the hospital ER 1:50 p.m., on December larged to the care of the 010, at 11:17 p.m. If the ER triage report 10, revealed, "No med list January 21, 2011, at 9:10 be Officer at hospital #3		281			
	confirmed the res	ident	was transferred to the ER					

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) I	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		ULTIPL LDING	E CONSTRUCTION	(X3) DATE S COMPLE	TED
			445303	B. WIN	ıG		Total Control and	C 3/2011
	ROVIDER OR SUPPLIER	BILITA	TION CENTER		338	ET ADDRESS, CITY, STATE, ZIP CO 2 ANDERSONVILLE HIGHWAY DERSONVILLE, TN 37705	DE	
(X4) ID PREFIX TAG	(EACH DEEICIENC	Y MUS'	T OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 281	information, including medications were produced interview confirmed the hosp information on the information to the February 8, 2011, Worker's office confirmed written to the hospital until December 17, 2012 Interview with the February 8, 2011, Worker's office conform, History and was placed in an enhospital when residently was placed in an enhospital when residently was transferred to the howard the Challed and Physical and provided to the howard was transferred C/O #27253 483.25(a)(3) ADL DEPENDENT REAL A resident who is daily living received.	ng a provice with pital direction of the following in the	st of the resident's led to the hospital. the Compliance Officer id not receive any written ant until the facility faxed al on the morning of s Social Worker on 00 a.m., In the Social d the resident was hospital #3 "around 4:30 ber 16, 2010, and r information including a fications was not provided bllowing morning on or of Nursing (DON) on 12 a.m., in the Social d a Change in Condition al, and medication list be and sent to the were transferred to the rview with the DON Condition form, History ation list had not been (#3) at the time resident ecember 16, 2010.		312			

PRINTED: 03/04/2011 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) FROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIF	PLE CONSTRUCTION	COMPLETED	
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	SUMMARY STA	BILITATION CENTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	A A	EET ADDRESS, CITY, STATE, ZIP CODE 882 ANDERSONVILLE HIGHWAY NDERSONVILLE, TN 37705 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	This REQUIREME by: Based on medical interview, the facilit and incontinence of of twenty-two resid The findings includ Resident #19 was December 17, 201 Vegetative State, If Contractures, Trace Injury, Quadriplegic Ulcers) and Urinar record review of the dated December 1 to be bedbound Coare, turn every 2 Medical record review of the Medical record review of the Vegetative State; for all activities of and had one Stage Ulcers. Medical record review of the dated February 4, reposition while in pressure reduction after each incontin Observation on Ferevealed RN #3 an (CNA) #3 position	record review, observation and bed frequently for comfort and the stage 4 Pressure in a persistent was provided for one (#19 lents reviewed. led: admitted to the facility on 0, with diagnoses of Persisten Deep Vein Thrombosis, theostomy, Traumatic Brain a, Chronic Decubiti (Pressure y Tract Infection. Medical le hospital Discharge Summan 7, 2010, revealed, "continue Chronic Decubitus Ulcerslocation in the MDS dated Februar the resident was in a Persisten was totally dependent on staff daily living; had a feeding tube of the resident's care plan 2011 revealed, "Turn and bed frequently for comfort and the provide incontinence care	d (sall y t	312	HOW WILL CORRECTIVE BE ACCOMPLISHED FOR RESIDENTS FOUND TO H. BEEN AFFECTED BY THE DEFICIENCT PRACTICE? Resident #19 was provided inc care and was repositioned once Resident has a care plan for in turning and repositioning due cranial issues and his limitatio turning secondary to Traumati injury. HOW WILL THE FACILIT IDENTIFY OTHER RESID HAVING THE POTENTIA AFFECTED BY THE SAM DEFICIENT PRACTICE? Residents who are dependent repositioning and who are inc at risk for this practice.	continent e identified. cremental to the ns of c brain	3/28/11

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	OF DEFICIENCIES F CORRECTION		ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIS	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
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	ROVIDER OR SUPPLIER HEALTH AND REHAI	3ILIT	ATION CENTER	3:	REET ADDRESS, CITY, STATE, ZIP CODE 382 ANDERSONVILLE HIGHWAY NDERSONVILLE, TN 37705		
	ALIMAN OTA	TELLE	IT OF DEFICIENCIES	QI	PROVIDER'S PLAN OF CORRECT	TION	(X5) COMPLETION
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F 312	the right lower butto	ock, o	ne on the coccyx and	F 312	WHAT MEASURES WILL INTO PLACE OR SYSTEM CHANGES MADE TO ENSI	IC :	
	one on the left butto revealed the reside small to moderate	nt ha	Continued observation d been incontinent of a nt of dark stool.		THAT THE DEFICIENT PF WILL NOT RECUR?		
	Interview with RN # observation confirm incontinence care.	3, at red ti	the time of the ne resident was in need of		The facility has developed a Re kardex system- assignment she incontinent needs as well as		
			2, 2011, at 11:10 a.m., at CNA #1 revealed CNA #1		turning/repositioning needs and updated daily M-F by the Unit		
	the nurses' station, with "came on duty at 6:00 a night shift CNA. CNA		m.", and relieved the reported, "not		The Resident Care Specialist w serviced by the SDC on 3/11/1		
	help out" Continue revealed the resident	ied ii nt wa	dayjust come over to terview with CNA #1 s positioned on the side #1 took report from the		regarding Incontinence care an expectations for dependent resi the electronic kardex system for	d turning idents using	
	night shift CNA and turned or reposition	con led the	irmed CNA #1 had not e resident or checked the since coming on duty at		Unit Mangers will randomly at kardex of 5 residents weekly ti weeks then monthly times 3 meas needed to determine if the ki	mes 4 onths then ardex list	
	the nurses' station	with ident	confirmed CNA #2 came		the Incontinence needs and turn for dependent residents and tha turning and incontinent care is	it the	
	repositioned or che incontinence from C/O #27531, #272	cked 7:00 : 23	the resident for a.m., until 11:00 a.m.		A weekly review of the Kardex will be made by the DON to de the kardex is in place for all res	etermine if	21-01
F 314 SS=D	483.25(c) TREATN PREVENT/HEAL F	RES	SURE SORES	F 314	MONITOR ITS CORRECT ACTIONS TO ENSURE TH	IVE AT THE	3/28/11
	resident, the facility who enters the faci	mus lity w	nsive assessment of a It ensure that a resident ithout pressure sores		DEFICIENT PRACTICE W RECUR?		
	individual's clinical they were unavoida pressure sores rec	cond able; eives	ire sores unless the tion demonstrates that and a resident having necessary treatment and ling, prevent infection and		Results of the random audits o managers and the DON will be to the QAA committee for 4 m issues are identified then modithe plan of correction will be n	presented onths. If fications to	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	OF DEFICIENCIES	(X1) E	ROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPI	LE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY TED
AND PLAN O	F CORRECTION	1	DENTIFICATION NUMBER:	A. BUIL	DING.			
			445303				03/03	3/2011
	ROVIDER OR SUPPLIER	BILIT	ATION CENTER		33	EET ADDRESS, CITY, STATE, ZIP COD 82 ANDERSONVILLE HIGHWAY NDERSONVILLE, TN 37705	Ε .	
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F 314	Continued From pa	age 1	0	F 3	314	F314	······································	31-21
	prevent new sores	from	developing.			HOW WILL CORRECTI BE ACCOMPLISHED FO	VE ACTION OR THOSE	3/28/11
	This REQUIREMENT is not met as evide by: Based on medical record review, facility province and intendent the facility failed to a					RESIDENTS FOUND TO BEEN AFFECTED BY TO DEFICIENCT PRACTIC	HAVE HE	
	Based on medical record review, facility policy review and interview, the facility failed to comple Pressure Ulcer risk assessments and/or weekly wound assessments for one resident with a Pressure Ulcer (#10) and failed to complete a dressing change as ordered by the physician ar					Resident #10 is not longer a and no further actions can be him.	t the facility te taken for	
	to provide timely recare for one (#19)	ange as ordered by the physician and imely repositioning and incontinence e (#19) with Pressure Ulcers of				Resident #19 received inco and incremental re-position identified	ntinent care ing once	
	twenty-two residents reviewed. The findings included: Resident #10 was admitted to the facility on October 19, 2010, with diagnoses including		ted to the facility on diagnoses including e Throat, Malnutrition,			HOW WILL THE FACE IDENTIFY OTHER RES HAVING THE POTENT AFFECTED BY THE SA DEFICIENT PRACTICE	IDENTS IAL TO BE .ME	#33 E
	Anxiety, Hemipare Tracheostomy and Accident (Stroke). Minimum Data Set	sis (p Hista Med (MD	aralysis on one side), bry of Cerebrovascular cal record review of the S) dated January 5, 2011,			Residents who are at risk f breakdown and dependent repositioning are at risk.		
	Minimum Data Set (MDS) dated January 5, 201 revealed the resident had no discernible consciousness and was totally dependent on state for all activities of daily living. Medical record review of the nursing admission assessment dated October 19, 2010, revealed a Stage 2 wound on the left sacral area, "0.03 ci (centimeter) X (by) 0.03 circular opening" and Stage 1 on the coccyx "with Duoderm cover."		totally dependent on staff iving.			WHAT MEASURES WI INTO PLACE OR SYST CHANGES MADE TO I THAT THE DEFICIEN'	EMIC ENSURE	
					WILL NOT RECUR? The facility has developed Care Specialist Kardex sys	a Resident tem assignment		
	(centimeter) X (by) 0.03 circular opening" and Stage 1 on the coccyx "with Duoderm cover." Medical record review of the care plan dated October 26, 2010, revealed the resident had a Pressure Ulcer and revealed, "Measure and stage wound weekly using the pressure ulcer healing assessment form"		f the care plan dated aled the resident had a caled, "Measure and ng the pressure ulcer			sheet listing the Incontiner repositioning needs of resi be updated M-F by the Un	dents that will	

	OF DEFICIENCIES OF CORRECTION		PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) N		IPLE CONSTRUCTION	(X3) DATE SL COMPLE	
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F 314	Medical record reviews at risk for the could be resident's risk of de not assessed again. Medical record reviews at risk for the could record dated records dated revealed the reside left heel which mea Continued review of dated December 16 Stage of the wound. Medical record reviews at resident had a Substage of the wound. Medical record reviews at 12 5 cm. Conskin assessments at 2010, revealed the seen assessed. Medical record reviews at 12 5 cm. Conskin assessments at 2010, revealed the seen assessed. Medical record reviews at 15 Stage of the wound. Medical record reviews at 15 Stage of the wound. Medical record reviews at 15 Stage of the wound. Medical record reviews at 15 Stage of the wound. Medical record reviews at 15 Stage of the wound.	ew content of the con	if the "Braden Scale-For e Risk" assessment revealed the resident poment of Pressure review revealed the bing a Pressure Ulcer was November 24, 2010. If the weekly Pressure rember 29, 2010, and a Stage 2 wound to the d 2.3 cm X 1.8 cm. Weekly skin assessments or 28, 2010, revealed the not been assessed. If the weekly Pressure rember 5, 2010, revealed a 3 wound on the m" which measured 8.1 and review of the weekly December 13 or 22, e of the wound had not the weekly Pressure rember 3, 2010, revealed age 3 wound on the left orm X 1.1 cm. Weekly skin assessments or 28, 2010 revealed the not been assessed. Ithe weekly Pressure rember 9, 2010, revealed age able wound on the left or 28, 2010 revealed the not been assessed.	F	314	The Resident care Specialist w serviced by the SDC on 3/11/1 regarding Incontinence care an turning/repositioning needs as kardex system. The Unit Managers will randor the kardex of 5 residents weekl weeks then monthly times 3 m determine if it listing includes incontinence and turning needs residents. The DON will review the kardetimes 4 weeks then monthly times months for 5 random residents compare it to the resident to det the care listed matches the care HOW WILL THE FACILITY MONITOR ITS CORRECTIVACTIONS TO ENSURE THADEFICIENT PRACTICE WILL RECUR? Results of the audits will be presthe monthly QAA committee for months. If issues are identified modifications will be made and continue,	d well as the well as the mly audit ly times 4 onths to sof the ex weekly nes 3 and termine if delivery.	

PRINTED: 03/04/2011

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 445303 03/03/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3382 ANDERSONVILLE HIGHWAY NORRIS HEALTH AND REHABILITATION CENTER ANDERSONVILLE, TN 37705 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 12 F 314 dated December 15, 22 dr 28, 2010, revealed the Stage of the wound had not been assessed. Review of the facility's policy for skin management revealed, "...1. Upon admission, all residents are assessed for skin integrity by completing a head to toe physical assessment of skin condition and completing the "Braden Scale-For Predicting Pressure Sore Risk" ... 2. Following admission, the Braden Scale...will be completed weekly for 3 additional weeks (for a total of 4 weeks including admission)...5. In addition, the following forms are completed and placed with the resident's Treatment Record: a. Pressure Ulcer: Weekly Pressure Ulcer Record...18. Pressure Ulbers are measured and staged weekly in accordance with the Practice Guidelines..." Medical record review and interview on February 9, 2011, at 4:35 p.m., with the Registered Nurse (RN) #1/Treatment Nurse confirmed the facility's policy for assessment of the resident's risk for the development of a Pressure Ulcer had not been followed, and the resident's risk of developing a Pressure Ulcer had not been assessed weekly for a total of four weeks after admission. Medical record review and interview on February 9, 2011, at 4:35 p.m. with RN #1/Treatment Nurse confirmed the facility's policy for assessing the stage of Pressure Ulbers weekly had not been followed, and the stage of the wounds on the left foot was not assessed on December 15, 22, and 28, 2010; the stage of the wound on the buttocks had not been assessed on December 13 or 22,

2010: the stage of the wound on the left heel had not been assessed on December 15, 22 or 28, 2010: and the stage of the wound on the right

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F 314	Continued From page 13 heel had not been asses 22, or 28, 2010.		F3	314				
	Contractures, Tracheoster Injury, Quadriplegia, Chrousers) and Urinary Tracrecord review of the hosp dated December 17, 201 to be bedbound Chronic care, turn every 2 hours Medical record review of 4, 2011, revealed the resident of all activities of daily liver and had one Stage 1 and Ulcers. Continued review Pressure Ulcer treatments or essure-reducing device turning/repositioning progntervention, and treatment	diagnoses of Persistent ein Thrombosis, my, Traumatic Brain nic Decubiti (Pressure Infection. Medical lital Discharge Summary), revealed, "continues Decubitus Ulcerslocal" The MDS dated February dent was in a Persistent ally dependent on staffing; had a feeding tube; three Stage 4 Pressure of the MDS revealed included a for the bed, a am, nutrition to of the Pressure Ulcers.						
M F E 2 tt	with dressings and applications. Medical record review of the Predicting Pressure Sore December 24, 2010, January 1, revealed the resident development of Pressure Sore development of Pressure Sore development of Pressured February 8, 2011, reference of the Pressure February 8, 2011, reference of the Pressure of the	ne Braden Scale-For Risk assessment dated ary 13 and February 4, It was at high risk for ire Ulcers. physician's order vealed, "Tx : Cleanse w/wc (with Apply Santyl to wound ound area. Apply						

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1)	ROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) N		TIPLE CONSTRUCTION	(X3) DATE S	
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F 314	bordered gauze. (C periwound area q (e (signs/symptoms) o (dressing) placement Medical record reviet dated February 8, 2 hip: Cleanse w/wc. (change) q 3 days 8 periwound area q sl infection, Monitor ds Medical record reviet dated February 8, 2 coccyx: Cleanse w/w hydrocollold dsg. (C Monitor periwound a Monitor dsg placement Medical record reviet dated February 4, 20 Ulcers were related perceptionMoistura activityImpaired m	change finfe ont q sew of 011, Appl PRI Appl PRI One one one of one one one one one one one one one one	re) daily. Monitor shift for s/s tion, Monitor dsg hift." a physician's order evealed, "Tx to L (left) hydrocolloid dsg, (as needed). Monitor s/s (signs/symptoms) of cernent q shift." a physician's order evealed, "Tx to ot dry. Apply le) q 3 days & PRN. shift for s/s of infection, shift." the resident's care plant evealed the Pressure Sensory shinenDecreased (Friction and shear	F	314			
	revealed the interver Pressure Ulcers included while in bed frequent reductionProvide incontinent episode. weekly using the pressure of the	ntion uded tly fo ncon Mea	"Turn and reposition comfort and pressure nence care after each sure and stage wound					
	completed and place	ed, ". ed wit	the following forms are					

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F 314	Pressure Ulcer Rec measured and stag the Practice Guideli Observation and int at 10:20 a.m., with t revealed the resider the right side, and a was in place on the 20, 2011. Interview with RN #3 confirms hip was dated Febru	erviewerself	Pressure ulcers are ekly in accordance with	F	314			
	10:20 a.m., revealed Assistant (CNA) #3 right side. Observati on the right lower but one on the left butto revealed the resider small to moderate at Interview with RN #3	t RN : position re ittock ck. C it had moun 3, at the						
	with the Director of I DON measured the coccyx-4.0 cm x (by buttocks-7.0 cm x 3. buttocks-4.0 cm x 1. Interview on Februa the nurses' station, v "came on duty" at 6:	Nursin Press) 1.0 c 0 cm 2 cm ry 22, vith C 00 a.r	k 0.1 cm; and right k 0.1 cm. 2011, at 11:10 a.m., at NA #1 revealed CNA #1 n., and relieved the					
	night shift CNA. CN assigned to (resident help out" Continue	t) tod	ayjust come over to					

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AND PLAN	OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE	A Property of the last of the
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	revealed the resider at 6:00 a.m., when 0 night shift CNA and turned or repositione resident for incontinuation of turned or reposition at turned or reposition at turned or reposition a.m., until 11:00 a.m. had not been checked interview on Februar Licensed Practical N #3 had "straightened" enough to give the ritreatment" earlier in 12011). Continued intonfirmed LPN #3, "onot perform incontinue hygiene for the residual pirector of Nursing on p.m., in the office reveassessments for the right hip and the ricompleted. Continue confirmed the facility pressure ulcer asses	it was conficed the conficed th	s positioned on the side #1 took report from the med CNA #1 had not resident or checked the since coming on duty. 2011, at 11:15 a.m., at NA #2, who was confirmed CNA #2 had the resident from 7:00 confirmed the resident incontinence. 2011, at 2:15 p.m., with (LPN) #3 revealed LPN resident's shoulders and a breathing orning (February 22, w with LPN #3 bt do a full turn" and did care or any grooming or I interview with the bruary 22, 2011, at 1:47 I weekly pressure ulcer ds on the left buttock, buttock had been erview with the DON no evidence the weekly its had been completed yx and the right buttock policy for weekly lcers had not been		314			
		ON re	vealed the DON had					

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		IPLE CONSTRUCTION	(X3) DATE	SURVEY LETED
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F 314	staff, and the DON weekly pressure uld completed for the wright buttock. C/O #27271, #2729	furth er a ound	er confirmed no evidence sessments had been s on the coccyx and the	FS	314		141	
F 323 SS=E	483.25(h) FREE OF HAZARDS/SUPER\ The facility must ensenvironment remains as is possible; and e	ACC /ISIC sure s as	IDENT N/DEVICES hat the resident ree of accident hazards	F3	23	F323 HOW WILL CORRECTIVE BE ACCOMPLISHED FOR RESIDENTS FOUND TO HA BEEN AFFECTED BY THE DEFICIENCT PRACTICE?	THOSE	3/28/11
	by: Based on medical re interview, the facility environment was free (#7) and failed to ens place for three (#10, residents reviewed. The findings included Resident #7 was admostic Left Sacroiliac and Paraspinal Absorber 27, 2010, with Septic Left Sacroiliac and Paraspinal Absorber Pain, Hypertens Anemia, and Frequent Medical record review (MDS) dated October	cord faile e of a sure #13, hitted th dia Join o He sion, of t	to the facility on agnoses including t, Right Retroperitoneal Anxiety, History of patitis C, Chronic Low Hypothyroidism, nary Tract Infections.			Resident #7- the shower room a been repaired and no leaking we observed at this time. This residence at the facility and no further actions can be taken. Resident #10 is no longer at the and no further actions can be taken. Resident #13 had a fall risk assecompleted on 3/14/11 by the DC interventions that include pressubed and chair, non skid socks, fileft side of bed. Care plan and I match the devices listed and are Resident #14 had a fall risk assecompleted on 3/1/11 by the DON Interventions include: pressure gand chair and the care Plan and I matches the devices currently in	facility fac	

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	FOF DEFICIENCIES OF CORRECTION		ROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
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F 323	skills; required limite mobility, transfers, a history of falls in the admission to the fac	ed as and a two cility. of wa	sistance with bed mbulation; and had no to six months prior to Medical record review discharged home with	F	323	HOW WILL THE FACILITY IDENTIFY OTHER RESIDE HAVING THE POTENTIAL AFFECTED BY THE SAME DEFICIENT PRACTICE? The Unit Managers and DON co	NTS TO BE	ı
	the resident was no	Octob t at ris	er 27, 2010, revealed k for falls.	*		walk through of the facility to it current safety devices the reside utilizing.	dentify ents are	
	November 17, 2010 stateswas transfer d/t (due to) water in	, reve rring i floor. d. Re	n bathroom & (and) fell Spill cleaned up, sident did not ask for	f		The identified safety devices we compared to the care Plan and Medetermine if each matches the Plane. WHAT MEASURES WILL BINTO PLACE OR SYSTEMS	Cardex to lan of E PUT	
	of the fall on Novem "Resident slipped cleaned & Maintena	ber 1 on wa nce v	ter in floor. Area was as notified"			CHANGES MADE TO ENSU THAT THE DEFICIENT PR. WILL NOT RECUR?	RE ACTICE	• • •
	Continued review re require medical trea	veale tmen	d the resident did not after the fall.			Nursing Admin (DON and Uni Managers) was in-serviced on a prevention program on 3/18/11 Admin and SDC. This include	fall by the	i
	from 11:00 a.m11: Director in the central (where resident #7 rentral bath, revealed had been replaced, that eroded leaving a wall of the central bathe resident's room. Maintenance Director of water would leak the rear the toilet when central bath. Contin	15 a.i bat eside ed the and the arting ath ar Con or corinto ti show ued of	d), which adjoined the tile in the central bath e grout around the tile crack" between the d the bathroom wall of the dinterview with the tirmed a small amount e resident's bathroom ers were given in the	ä		investigations to determine if the devices were alarming at the tire	ne safety	8

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	TO THE PARTY OF TH	CA IV	LDIONID OLIVICES				OMB MC). 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPL	ETED
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	three walls of the ce which adjoined the r which adjoined the r Interview on Februa the Assistant Direct Coordinator confirm fall on November 17 in the bathroom floo repaired by the Mair Resident #10 was re October 19, 2010, w Throat Cancer, Oste Herniparesis, Anxlet CVA and Tracheoste of the facility History 20, 2010, revealed the priented. Medical redated November 24, had no impairment on the facility. Medical resident expired in the Medical record review assessments dated C24, 2010, and Januar esident was at high a Medical record review assessment injury. Reviewed the facility of the facility and December 24 and December 25 and December 26 and December 26 and December 27 and December 28 and December 28 and December 29 and	rout retraction of the condition of the	had been applied to bath including the wall ent's room. 3, 2011, at 2:25 p.m., with Nursing(ADON)/Falls to doubt" the resident's 11, was because of water of the leak had been not birector. Itted to the facility on agnoses including writis, Osteoporosis, pertension, History of Medical record review Physical dated October sident was alert and review of the MDS 0, revealed the resident ision-making skills and withs prior to admission ford review revealed the cility on January 6, 2011. The "Fall Risk" ber 19 and November 2011, revealed the or falls. ealed the resident was or beside the bed on r 6, 2010, with no of the facility's realed a pressure pad were put in place.	F	323	Licensed Nurses were in-service prevention program on 3/11/11 SDC that included investigation for placement of the safety developed and alarms sounding if a occurs. An electronic kardex assignment was developed for the Resident Specialist to utilize delivering of Kardex system was in-serviced RC's by the SDC. The Kardex updated M-F by the Unit Mananeeded on Sat-Sun by the clinic supervisor. DON or Unit Managers will ran audit 3 residents on each hall resafety devices cach week times then monthly times 3 months to if the safety devices are in place functioning correctly. HOW WILL THE FACILITY MONITOR ITS CORRECTIVACTIONS TO ENSURE THADEFICIENT PRACTICE WIRECUR? Results of the random audits will presented to the monthly QAA of for 4 months. If identified issue noted then modifications to this correction will be made.	by the n of events rices was in falls nt sheet t Care care. The to the will be gers and if cal idomly equiring 4 weeks determine and VE TTHE LL NOT	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	(X3) DATE S COMPLI	
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PREFIX (EACH DEFICIENCY MU	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
with "L (Left) side of on L side of head" Merevalled no document clip alarm were in place of the fall. Medical receinvestigation revealed the bed after the fall. Medical record review December 14, 2010, a "Resident observed Review of the facility's December 14, 2010, rethe pressure pad and coperating at the time of Interview on February the office with the ADC confirmed the resident high risk for falls, and to October 24, December 14, 2010 the ADON/Falls Coord pressure pad alarm, a been put in place to reresident falling. Contin ADON/Falls Coordinate policy for investigation determination of wheth been put in place, were fall. Continued interview Coordinator confirmed knowledge if the pad a place at the time of the 2010. Continued interview Coordinator confirmed put in place after the fall pla	on the floor beside the bed head bleedingabrasion ledical record review atton the pressure pad and and operating at the time ord review of the facility's 'bolsters' were placed on of a post fall review dated 7:00 p.m., revealed, ying on floor next to bed." investigation of the fall on evealed no documentation slip alarm were in place and fithe fall. 16: 2011, at 10:50 a.m., in on Falls Coordinator had been assessed at the resident had fallen on and two separate times. Continued interview with inator confirmed a clip alarm and bolsters had duce the risks of the used interview with the confirmed the facility's of falls included making a er interventions, which had a if place at the time of a with the ADON/Falls the facility had no not clip alarms were in two falls on December 14, view with the ADON/Falls the bolsters, which were	F	323		

	T OF DEFICIENCIES OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) N		TIPLE CONSTRUCTION	(X3) DATE S	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUS	NT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	enough and one hainstructon applica Resident #13 was a August 27, 2010, with ypertension, Anemwith Hemodialysis a review of the MDS or revealed the resider memory problems a decision-making ski assistance with bed unsteady balance with standing position, mwith transfers betwee had no history of fall admission to the factorial memory and provided the August 27 and January 4, 2011, revealed August 27 and January 4, 2011, revealed for falls. Medical record revied the formal for the revealed, "fall on 11/(no) injury noted. Repathered for the formal for the formal for the formal formal for the formal formal formal for the formal for the formal formal formal formal formal formal formal formal for the formal f	di modition di di modition di modition di modition di moditioni di mod	red to the facility on agnoses including ind-Stage Renal Disease labetes. Medical record December 20, 2010, If short and long-term oderately impaired equired extensive lity and transfers; had an moving from a seated to go and off the toilet and the bed and chair; and the six months prior to "Fall Risk" assessments cember 20, 2010, and the resident was at a "IDT" (Interdisciplinary November 10, 2010, © 5:40 p.m. in room Int statedhad to go to call light. Intervention is resident" In a nurse's note dated aled, "sitting In floor noted" Review of the the fall revealed no as in place at the time of the investigation		323			

			TENONIO CENTOLO		-		CIMID MC	J. U930-U39 I
	T OF DEFICIENCIES OF CORRECTION	(X1)	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION DING	(X3) DATE S	ETED
			445303	B. Wil	NG .		03/	C 03/2011
Barre Mani raspetitinos	PROVIDER OR SUPPLIER HEALTH AND REHA					TREET ADDRESS, CITY, STATE, ZIP CODE 3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUS	NT OF DEFICIENCIES BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Medical record revidence of the falls on January 4, 2011, respectively and place at the time of the clip alares with the Alconfirmed a clip alares with the Alconfirmed the ADOI the clip alarm was infall on December 25 had no knowledge if the time of the falls and confirmed non-at the time of the fall of Gastrointestinal Refilip with Left Hemi-Areview of the MDS of revealed the resider decision-making skill assistance with bed ambulation; was unstant.	ew of the control of	a nurse's note dated d, "Res. sitting in floor @ bathroom and slid out. edical record review of a lary 6, 2011, revealed, in floor. (No) injuries facility's investigation of d 6, 2011, revealed no or non-skid socks were in alls. 14, 2011, at 9:50 a.m., at 10:05 a.m., and 2:10 at lying in bed with a ace. 2011, at 2:28 p.m., in VFalls Coordinator as put in place after the r 2, 2010. Continued Falls Coordinator s Coordinator observed blace at the time of the 0; confirmed the facility dlip alarm was in place at huary 4 and 6, 2011; ocks were not in place anuary 6, 2011. ed to the facility on May including Dementia, sease and Fractured plasty. Medical record December 7, 2010, no impairment of quired extensive	F	323	3		

NO1 ZZ	ZUII 12.44	0004	J40043	110	IZIZE	O FILMETTE GIVETIME	1 1101-	
			HUMAN SERVICES					03/04/2011 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) F	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	red
			445303	B, WI	۱G			3/2011
	ROVIDER OR SUPPLIER HEALTH AND REHA	BILITA	ITION CENTER		33	EET ADDRESS, CITY, STATE, ZIP CODE 382 ANDERSONVILLE HIGHWAY NDERSONVILLE, TN 37705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST	IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	on and off the tolle bed and chair; was bladder; and had at to six months prior. Medical record rev dated May 27, Jun December 7, 2010 high risk for falls. Review of a "Chan December 12, 201 alarm. Found resibedno injuries no "Interdisciplinary P December 12, 201 offbedwill apply mattress in use!! Recommendations. Medical record rev December 17, 201 floor sitting beside. Medical record rev of the fall dated Doresident reported. Observation on Ferevealed the residin place.	d and income history to add iew or e 3, 5, reverse of the control	ransferring between the tinent of bowel and y of falls in the prior one mission. the fall risk assessments eptember 7, and aled the resident was at Condition" dated ealed, "Heard clip floor sitting up beside "Review of the facility's all Review' dated ealed, "Had slid ters as long as air nition alarm" a nurse's note dated ealed, "Found resident in No injury noted" the facility's investigation er 17, 2010, revealed the	F	323			

Observation on February 15, 2011, at 9:20 a.m., revealed the resident lying in bed on the left side. Observation revealed the base of the clip alarm

in place.

PRINTED: 03/04/2011 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) F	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUR COMPLETE	ED
AND FUNIA OF	CONNECTION			B. WING		- 03/03/	
NAME OF BE	OVIDER OR SUPPLIER	L	445303	ST	REET ADDRESS, CITY, STATE, ZIP CODE	001007	2011
	EALTH AND REHA	BILITA	TION CENTER		3382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST	T OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	not visible. Observation and in at 9:25 a.m., with L #1 revealed LPN # and the clip had be Interview with LPN was not attached to Observation on Ferevealed the reside bedside with the bon the back of the attached to the reside bedside with the boack of the chair a dangling down the attached to the reside bedside with the boack of the chair a dangling down the attached to the residency of #26871, #27483.75(I)(1) RES RECORDS-COMILE The facility must resident in according to the proposed propos	tervie licens 1 rais 2 fen re 41 co o the bruar ent was ase o chair ent sident sident residen	w on February 15, 2011, ed Practical Nurse (LPN) ed the resident's pillow, moved from the cord. onfirmed the clip alarm resident. v 15, 2011, at 2:15 p.m., as sitting in a chair at the the clip alarm secured land the clip alarm secured land the clip alarm secured land the clip alarm secured to the ether alarm secured to the the alarm secured to the cord and clip was of the chair and was not the confirmed the clip to the resident. 27223, #27271, #27297 E/ACCURATE/ACCESSIB an clinical records on each with accepted professional that are complete; readily accessible; and	F 323	HOW WILL CORRECTIVE BE ACCOMPLISHED FOR RESIDENTS FOUND TO HEBEN AFFECTED BY THE DEFICIENCY PRACTICE?	ment icensed fied no new that the pr the right	3/28/16
			1				A AA . 4 - 4

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) [ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY TED
AND PLAN O	FORREGION	,	ENTITION NOMES	A. BUI				;
			445303	B. Wit	VG		03/03	3/2011
	ROVIDER OR SUPPLIER HEALTH AND REHA	BILIT/	TION CENTER		33	REET ADDRESS, CITY, STATE, ZIP CODE 382 ANDERSONVILLE HIGHWAY ANDERSONVILLE, TN 37705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST	IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	resident's assessmervices provided; preadmission scree and progress notes and progress notes the facility failed to complete for two (# reviewed. The findings included Resident #6 was an 14, 2006, with diagnomentia, Alzheim Seizure Disorder and Disorder. Medical Data Set dated Ocresident had short problems and seventials and was total activities and daily Medical record revealed, "R (right (centimeters)area covering. Cover (v (Change) QD (eventimeters) and cover the assessment reventing the characteristic provides and coveristic the name of the characteristic provides and coveristic the name of the characteristic provides and provides assessment revention to the characteristic provides and p	ify the reserving it the reserving it. NT is record ensured, #1 ed: dmitte er's End Perecord it tober and it is record it is in the rely if it is in the rely in the rely in the rely if it is in the rely in the	resident; a record of the the plan of care and sults of any conducted by the State; not met as evidenced for review and interview, the the medical record was 0) of twenty-two residents of twenty-two residents of the facility on March sincluding Severe disease, Hypertension, tripheral Vascular disease, review of the Minimum 28, 2010, revealed the long-term memory mpaired decision-making bendent on staff for all the "Non-Pressure Skin January 20, 2011, nlesion1.0 d, scabbedcrusty ry dsg (dressing). Tontinued review of the documentation did the resident; a description the wound or wound bed;	F	514	HOW WILL THE FACILITY IDENTIFY OTHER RESIDE HAVING THE POTENTIAL AFFECTED BY THE SAME DEFICIENT PRACTICE? Licensed Nurses were in-service wound care documentation exploy the Don and SDC including skin checks with documentation describing the wound. B) Treat orders for all identified areas the cleaning agent, wound treat cover dressing (if appropriate). WHAT MEASURES WILL INTO PLACE OR SYSTEM CHANGES MADE TO ENSITHAT THE DEFICIENT PROBLEM OF THAT THE DEFICIENT PROBLEM OF SYSTEM CHANGES WILL NOT RECUR? A weekly skin audit of 5 randowill be conducted by the DON Managers times 4 weeks then a 3 months to validate if the documented sudits will also validate if the sare being documented on the Tindicating the treatment is being indicating the treatment is being the sare being documented on the Tindicating the treatment is being the sare being documented on the Tindicating the treatment is being the sare being documented on the Tindicating the treatment is being the sare being documented on the Tindicating the treatment is being the sare being documented on the Tindicating the treatment is being the sare being documented on the Tindicating the treatment is being the sare being documented on the Tindicating the treatment is being the sare being documented on the Tindicating the treatment is being the sare being documented on the Tindicating the treatment is being the same treatment is the same treatment is the same treatment is being the same treatment is the same treatment in the same treatment is the same treatment in the same treatment in	ed on ectations A) weekly no ment lat includes ment, and BE PUT IC URE LACTICE om residents and Unit monthly for later l	
	and a description of Medical record rev		a physician's order			=		

MODITA HERETH GIVENING

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) I	ENTIFICATION NUMBER: A. BUILDING 445303 B. WING			C 03/03/2		
	ROVIDER OR SUPPLIER HEALTH AND REHA	BILIT	TION CENTER		33	EET ADDRESS, CITY, STATE, ZIP CODE 82 ANDERSONVILLE HIGHWAY NDERSONVILLE, TN 37705		MO
(X4) ID PREFIX TAG	CACH DEDOIENC	PLIM V	T OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	ID PREFI TAG	(2.00	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE
F 514	dated January 20, R lower ext (extrepat dry, apply dry (as needed)." Medical record record record reducted January 20 documentation with January 21, 22, 20 Observation on Frevealed the resident with a gleg. Telephone intervized by Telephone intervized the as documentation diresident; a descriwound or wound drainage. Telephone intervizes p.m., with Lireviewed the "He January 26, 201 assessment; and the resident.	view of nuary of nuary of not in view of a 1, 25, and of a 25, and of	revealed, "Clean area to with) NS (normal saline), hange) QD & (and) prn If the "Head to Toe Skin 26, 2011, revealed the dentify the resident. If the Treatment Record 11, revealed no are was provided on 28, 29, 30, 31, 2011. If 7, 2011, at 10:35 a.m., as positioned in a reclined thandage on the right lower and age on the right lower dition Report" dated confirmed LPN #4 hent, and the include the name of the of the characteristics of the and a description of the characteristics of the and a description of the characteristics of the characteris		514	HOW WILL THE FACILIT MONITOR ITS CORRECT ACTIONS TO ENSURE THE DEFICIENT PRACTICE WERECUR? Results of the random audits we presented to the QAA commit times 4 months. If identified in noted then modifications will this plan of correction.	IVE AT THE TILL NOT will be tee monthly ssues are	
	3:25 p.m., with ti	ne Dir	ettor of Nursing					t Page 27 of 2

N2/ 77/ 7011 17.44 0004040040 DUNKSO TIEMETTI GINETIE PRINTED: 03/04/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED MENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 03/03/2011 445303 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3382 ANDERSONVILLE HIGHWAY NORRIS HEALTH AND REHABILITATION CENTER ANDERSONVILLE, TN 37705 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 514 Continued From page 27 F 514 (DON)confirmed the DON had reviewed the Treatment Record dated January 20-31, 2011, and there was no documentation wound care had been provided on January 21, 22, 24, 25, 28, 29, 30, 31, 2011. Resident #10 was admitted to the facility on October 19, 2010, with diagnoses including Cancer of the Base of the Throat, Malnutrition, Anxlety, Herniparesis (paralysis on one side), Tracheostomy and History of Cerebrovascular Accident (Stroke). Medical record review of the Minimum Data Set dated October 29, 2010, revealed the resident had moderately impaired decision-making skills. Medical record review of the nursing admission assessment dated October 19, 2010, revealed a Stage 2 wound on the left sacral area, "...0.03 (centimeter) X (by) 0.03 circular opening..." and a Stage 1 on the coccyx "with Duoderm cover." Continued review of the nursing admission assessment dated October 19, 2010, revealed the assessment had not been signed or dated by the nurse. Medical record review and interview on February 9, 2011, at 4:03 p.m., with the Director of Nursing in the Social Worker's office confirmed the initial nursing assessment dated October 19, 2010, had

not been signed or dated by the nurse. C/O #26879, #27271, #27297, #27531